Chutes and Ladders
Climb Out of Wound Downslides

HCAC Annual Conference 2019

Wound Guidance
NPUAP, WOCN, OASIS-D, ICD-10-CM Diagnosis Coding
Pressure Ulcer Defined

• A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure (NPUAP)

• Localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. (CMS)

• NOT pressure ulcers: Serum filled blisters that are caused by shoes rubbing against the foot

• Does not include mucosal pressure ulcers

Stage 2 or DTI?

Examine the area surrounding an intact blister (stage 2 pressure ulcer) for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to or surrounding the blister demonstrates signs of tissue damage (e.g. color change, tenderness, bogginess/firmness, warmth or coolness), these characteristics suggest a deep tissue injury (DTI) instead of a stage 2 pressure ulcer

<table>
<thead>
<tr>
<th>Stage 2</th>
<th>DTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pink red wound bed</td>
<td>Dark wound bed</td>
</tr>
<tr>
<td>Serum filled blister</td>
<td>Blood filled blister</td>
</tr>
</tbody>
</table>
Stage 4 Staging Tips

- Granulation and no exposed bone, tendon or muscle
- Slough or eschar
- Slough or eschar without exposed bone, tendon or muscle
- Stage based on previous documentation; do not reverse stage

Unstageable

- Known or likely but not stageable due to non-removable dressing or device
  - Includes those that are sutured
- Known or likely but not stageable due to coverage of wound bed by slough and/or eschar (no stage 4 structures can be visualized)
  - A scab is not the same as eschar (removed from Q&A)
- Suspected deep tissue injury in evolution.
Updated Guidance - NPUAP

• NPUAP updated terminology for staging (Pressure ulcer now pressure injury)

• Home health agencies may adopt the NPUAP guidelines in their clinical practice and documentation. However, since CMS has adapted the NPUAP guidelines for OASIS purposes, the definitions do not perfectly align with each stage as described by NPUAP.

• When discrepancies exist between the NPUAP definitions and the OASIS scoring instructions provided in the OASIS Guidance Manual and CMS Q&As, providers should rely on the CMS OASIS instructions.

Closed Stage 3 and 4 Ulcer/Injury

• Stage 3 and 4 (full thickness) pressure ulcers heal through a process of granulation (filling of the wound with connective/scar tissue), contraction (wound margins contract and pull together), and re-epithelialization (covers with epithelial tissue from within wound bed and/or from wound margins).

• Once the pressure ulcer has fully granulated and the wound surface is completely covered with new epithelial tissue, the wound is considered closed, and will continue to remodel and increase in tensile strength. For the purposes of scoring the OASIS, the wound is considered healed at this point, and should no longer be reported as an unhealed pressure ulcer.
Flaps, Grafts, Debrided, Closed

- A pressure ulcer treated with any kind of flap or graft is considered a surgical wound on OASIS until 30 days after complete re-epithelialization.
- A pressure ulcer that has been surgically debrided is still a pressure ulcer.
- If a pressure ulcer is stage 4 at SOC and is granulating at the follow-up visit, the ulcer remains a stage 4 ulcer.
- A previously closed stage 3 or stage 4 pressure ulcer that breaks down again should be staged at its worst stage.
- In order to stage the pressure ulcer as a stage 4, bone, muscle, tendon, or joint capsule (stage 4 structures) must be visible. A pressure ulcer that has some degree of necrotic tissue (eschar or slough) or scabbing present that the clinician believes may be obscuring the visualization of stage 4 structures cannot be staged, even if it was previously stageable.

M1306: Revised Item

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
<td>Go to SOC/ROC/FU; Go to M1324 at DC</td>
</tr>
<tr>
<td>1</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

No—Stage 1 and all ‘healed’ ulcers
Yes—Stage 2 or higher and unstageables
### M1306 Synopsis

**NO**

- Stage 1 pressure ulcers.
- Healed Stage 2 pressure ulcers (once epithelialized no longer considered a pressure ulcer)
- Healed Stage 3 pressure ulcers (healed for the purposes of scoring OASIS—continue to be at risk)
- Healed Stage 4 pressure ulcers (healed for the purposes of scoring OASIS—continue to be at risk)

**YES**

- Stage 2 pressure ulcers
- Stage 3 Unhealed
- Stage 4 Unhealed
- Unstageable
  - presence of non-removable dressing/device
  - presence of necrotic tissue that obscures visualization of stage 4 structures (bone, muscle, tendon or joint capsule) *presence of eschar/slough*
  - Suspected deep tissue injury in evolution

### M1311 Current Number of Unhealed Pressure Ulcers

<table>
<thead>
<tr>
<th>(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers</td>
<td>☐</td>
</tr>
<tr>
<td>B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers</td>
<td>☐</td>
</tr>
<tr>
<td>C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers</td>
<td>☐</td>
</tr>
<tr>
<td>D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</td>
<td>☐</td>
</tr>
<tr>
<td>E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</td>
<td>☐</td>
</tr>
<tr>
<td>F1. Unstageable: Deep tissue injury: Known but not stageable due to coverage of wound bed by eschar. Number of unstageable pressure injuries presenting as deep tissue injury</td>
<td>☐</td>
</tr>
</tbody>
</table>
### M1311 Current Number of Unhealed Pressure Ulcers

<table>
<thead>
<tr>
<th>Discharge</th>
<th>M1311 Current Number of Unhealed Pressure Ulcers</th>
<th>Injuries at Each Stage</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1. Stage 2: Partial thickness area presenting as a shallow open ulcer with red or pink wound bed, without slough. May also present as an intact or open/necrotic blister. Number of Stage 2 pressure ulcers</td>
<td>[F5 – Go to M1311I]</td>
<td>Stage 2</td>
<td></td>
</tr>
<tr>
<td>A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers</td>
<td>[F5 – Go to M1311C]</td>
<td>Stage 3</td>
<td></td>
</tr>
<tr>
<td>B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Offers includes undermining and tunneling. Number of Stage 4 pressure ulcers</td>
<td>[F5 – Go to M1311D]</td>
<td>Stage 4</td>
<td></td>
</tr>
<tr>
<td>C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1. Unstageable: Non-removable dressing/device known but not stageable due to non-removable dressing/device. Number of unstageable pressure ulcers listed due to non-removable dressing/device</td>
<td>[F5 – Go to M1311E]</td>
<td>Unstageable: Non-removable dressing/device</td>
<td></td>
</tr>
<tr>
<td>D2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</td>
<td>[F5 – Go to M1311F]</td>
<td>Unstageable: P. Pressure Ulcer</td>
<td></td>
</tr>
<tr>
<td>E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F1. Unstageable: Deep tissue injury Number of unstageable pressure wounds present as deep tissue injury</td>
<td>[F5 – Go to M1311G]</td>
<td>Unstageable: Deep tissue injury</td>
<td></td>
</tr>
<tr>
<td>F2. Number of these unstageable pressure wounds that were present at most recent SOC/ROC</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**The First Skin Assessment**

- Report pressure ulcer/injury stage (or unstageable) based on the *first skin assessment*

- Do NOT change OASIS coding if the ulcer/injury increases in numerical stage (i.e. worsens) or becomes stageable or unstageable within the assessment time period
  - If a pressure ulcer identified on the SOC date increases in numerical stage within the 5 day assessment time period, the stage of the pressure ulcer/injury at the first skin assessment completed would be reported in M1311x1 on the SOC OASIS.

- Skin assessment should be completed as close to the actual time of the SOC/ROC as possible
Determining Present on Admission

• For the OASIS, “Present on Admission” and “Present at SOC/ROC” have equivalent meanings
  • Stage identified at first skin assessment
  • At discharge
    • If ulcer was unstageable at SOC/ROC = first documentation ulcer became numerically stageable
• Discharge: For each pressure ulcer, determine whether that pressure ulcer was present at that same site and at the same stage at the time of the most recent SOC/ROC, and did not form during this home health quality episode.

OASIS-D New Guidance

• Any numerically stageable pressure ulcer/injury observed at SOC/ROC that is unstageable due to slough and/or eschar at DC, should be considered new and not coded as present at the most recent SOC/ROC for M1311x2
• If an unknown pressure ulcer/injury is discovered upon removal of a non-removable dressing or device, that pressure ulcer/injury should be considered new, and not be coded as present at the most recent SOC/ROC for M1311x2
Cannot Change Assessment on M1311

Example: Pressure ulcer is assessed as covered with eschar and slough at SOC. Ulcer is debrided on Day 3 of episode and ulcer is staged at 4.

- M1311 CANNOT be updated to stage 4 on the SOC assessment.

Example: Pressure ulcer assessed as covered with a nonremovable dressing at SOC. Patient returns to clinic on day 3 and nurse documents on day 4 that it is a stage 3.

- M1311 CANNOT be updated to stage 3.
Only applies to pressure ulcers...

If a patient has a non-removable dressing on when the assessing clinician admits, could a different clinician report the wound status to the assessing clinician if the dressing is removed within the assessment time frame?

**Depends on the type of wound involved**

**Pressure Ulcers:** the first clinical skin assessment must be used to complete the OASIS pressure ulcer items

**Stasis Ulcers and Surgical Wounds:** OASIS guidance allows agency to use any skin assessment conducted during the assessment time frame to code other OASIS wound items. Guidance does not limit coding to only data from the first clinical skin assessment.

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When did the skin assessment occur?

The OASIS pressure ulcer items should be coded based on findings from the first skin assessment that is conducted on or after, and as close to the SOC or ROC date as possible. **If the first time a skin assessment could be done is on the second home health visit, and a pressure ulcer is identified during that assessment, then it should be reported on OASIS, as that would represent the initial skin assessment.**

If a skin assessment was conducted on the SOC visit and no pressure ulcer was identified, then a subsequent skin assessment was conducted on the second visit and a pressure ulcer was identified, the pressure ulcer would **not** be reported on the OASIS at that time point, since the pressure ulcer status should be based on the first skin assessment conducted at the SOC/ROC time points.
**M1322: Revised Item**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Number of Stage 1 Pressure Injuries:</strong></td>
<td>Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Although Stage 1 pressure injuries are closed (intact skin), they would not be considered healed.

**M1324: Revised Item**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable:</strong> (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 1</td>
<td>Stage 2</td>
<td>Stage 3</td>
<td>Stage 4</td>
<td>Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries</td>
<td></td>
</tr>
</tbody>
</table>

“Most problematic” may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.
M1330 Does this patient have a Stasis Ulcer?

Identifies patients with ulcers caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis. Stasis ulcers DO NOT include arterial lesions or arterial ulcers. Response 3--Information may be obtained from the physician or patient/caregiver regarding the presence of a stasis ulcer underneath the cast or dressing.

M1332 Current Number of Stasis Ulcers

If ulcers are contiguous and developed at same time = 1 stasis ulcer
If one venous stasis ulcer present and later another forms = 2 stasis ulcers if margins are distinguishable
If multiple ulcers enlarge and merge and margins are not visible = 1 stasis ulcer
Use clinical judgement to determine number
Mixed Arterial and Venous Disease

• In a situation where the patient has a mixture of venous stasis and arterial disease, the wound appearance and characteristics allows the physician determine if the ulcer is venous, arterial, or mixed.

• Venous stasis ulcer, or a mixed arterial and venous ulcer - mark as stasis ulcer in M1330.

• Arterial and it is receiving clinical assessment or intervention from the home health agency, the assessing clinician would document the wound in the clinical skin assessment (January 2016).

Trauma Wound or Stasis Ulcer?

• Our patient’s lower extremity wound originated as a trauma wound due to a fall. The patient also has diagnoses of venous insufficiency and stasis dermatitis. The physician stated the wound is not healing due to the venous insufficiency. Is there a point in time when the wound is no longer classified as a traumatic wound and considered a stasis ulcer for M1330?

• Ulcers caused by inadequate circulation in the area affected. The healing process of other types of wounds, e.g. traumatic wounds, surgical wounds, burns, etc., may be impacted by the venous insufficiency, but it would not change the traumatic or surgical wound into a venous stasis ulcer.

• 4bQ100.01.
M1334 Status of Most Problematic Stasis Ulcer

1. Determine which stasis ulcers are observable
2. Determine which stasis ulcer is most problematic, then
3. Determine and report healing status

Healing Status

**Fully Granulating:**
- wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium;
- no dead space, no avascular tissue (eschar and/or slough);
- no signs or symptoms of infection;
- wound edges are open

**Early/Partial Granulation:**
- wound with ≥25% of the wound bed covered with granulation tissue;
- <25% of the wound bed covered with avascular tissue (eschar and/or slough);
- may have dead space;
- no signs or symptoms of infection;
- wound edges open

**Not Healing:**
- wound with ≥25% avascular tissue (eschar/slough)
- OR s/sx of infection
- OR clean but non-granulating wound bed
- OR closed/hyperkeratotic
- wound edges OR persistent failure to improve despite appropriate comprehensive wound management
M1340 Surgical Wound

• Old surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds and should not be included in this item.

• If patient has both observable and unobservable wounds, the best response is 1 – Yes, patient has at least one observable surgical wound.

• Response 2 if only surgical wound(s) is/are not observable. Not observable = covered by a dressing/device (such as a cast) which is not to be removed per physician order.
  • *This response can be updated during the timeframe.*

• A surgical site is generally documented as a surgical wound until re-epithelialization has been present for approximately 30 days. After 30 days, it is generally described as a scar and should not be included in this item.
### Surgical Wounds

<table>
<thead>
<tr>
<th>Surgical Wounds</th>
<th>Not A Surgical Wound</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pressure ulcers with muscle flaps or skin grafts (breaks down during healing—non healing surgical wound)</td>
<td>• Pressure ulcers sutured closed</td>
</tr>
<tr>
<td>• <em>Also can be a pressure ulcer and surgical wound at the same time</em></td>
<td>• Paracentesis</td>
</tr>
</tbody>
</table>
| • Any ulcer with skin graft                                                   | *
| • Excised pressure ulcers Q94.1                                                | As long as present in body, regardless whether functional*|
| • Dialysis cath exit sites (AV fistulas, AV shunts)                             |                                                          |

### Surgical Wounds

<table>
<thead>
<tr>
<th>Surgical Wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Central lines centrally inserted (i.e., internal jugular or subclavian or axillary vein)</td>
</tr>
<tr>
<td>• Implanted infusion devices*</td>
</tr>
<tr>
<td>• ON-Q catheter sites</td>
</tr>
<tr>
<td>• Implanted pumps*</td>
</tr>
<tr>
<td>• Cardiac cath by cutdown</td>
</tr>
<tr>
<td>• VANTAS implanted device*</td>
</tr>
<tr>
<td>• Electrodesiccation and curettage</td>
</tr>
<tr>
<td>• MammoSite® breast brachytherapy</td>
</tr>
</tbody>
</table>

### Not surgical wounds

<table>
<thead>
<tr>
<th>Not surgical wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Peripherally inserted (PICC) lines (tunneled and non-tunneled) *</td>
</tr>
<tr>
<td>• Cardiac cath by needle puncture</td>
</tr>
<tr>
<td>• Toenail removal</td>
</tr>
<tr>
<td>• Cryosurgery</td>
</tr>
</tbody>
</table>
Surgical Wounds

**Surgical Wounds**

- I&D with drain
- Excision
- Wound with drain even after drain pulled
- Shave, punch or excisional biopsy
- Repair of a internal trauma
- Take down of ostomy
- **Burn with a skin graft**

**Not Surgical Wounds**

- I&D without drain
- I&D of foot ulcer with biopsy of bone (2nd Q 2015)
- Removal of a callus
- Repair of a traumatic laceration
- Thoracotomy or any wound ending is ostomy
  - Surgical incision to insert chest tube

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**Surgical Wounds**

**Surgical Wounds**

- Pacemakers and internal defibrillators until epithelialized for 30 days
- LVAD
- VP shunts and burr holes
- Donor site for grafts
- Laparoscopic surgery, arthroscopy, and other minimally invasive surgery/procedure
- Kyphoplasty by open approach

**Not Surgical Wounds**

- Pacemakers and internal defibrillators once epithelialized for 30 days
- Retention sutures, staple sites
- Kyphoplasty by percutaneous approach
- Cataract surgery
- Gynecological surgery via vaginal approach
- Mucous membranes (dental)
Infusion Pumps

Q: Are insulin and morphine pumps captured in M1030, Therapies at Home and M1340, Surgical Wounds?

A: A pump infusing medication while patient is at home is reported as Response 1 in M1030. This is true whether it is an infusion via an implanted device or an infusion via an external pump. *If the infusion device is implanted, it would also qualify as a surgical wound under M1340*. An external device infusing medication via a SQ needle is *not* counted as a surgical wound.

Venous Access/Infusion Devices

- For implanted venous access devices and infusion devices:
  - Once the insertion site is healed, score status as “0 - Newly epithelialized” from that point onward (as long as port or device in place)
  - If port has needle access in place, status remains “3 - Not healing” while the needle or line is in place
1. Determine which surgical wounds are observable
2. Determine which observable surgical wound is most problematic, then
3. Determine and report healing status

Pressure Ulcer Coding

- Assign as many codes in L89.- category that are needed to identify all the pressure ulcers the patient has
- Assignment of pressure ulcer stage can be based on:
  - Documentation from the provider
  - Documentation from the agency clinician
- If documentation states pressure ulcer is completely healed (not closed), then do not code the pressure ulcer
- NPUAP and WOCN guidance:
  - Reverse staging is not allowed
  - Stage 3 and Stage 4 ulcers never “heal” but close, and therefore may be coded based on interventions the agency may be performing (assessment and prevention are interventions!)
Non-Pressure Ulcer Coding

- ICD-10 coding requires assessment and documentation of the depth of tissue injury:
  - Limited to breakdown of skin
  - With fat layer exposed
  - With necrosis of muscle
  - With necrosis of bone
  - With muscle involvement without evidence of necrosis
  - With bone involvement without evidence of necrosis
- May be coded based on clinician documentation of the depth of tissue injury, physician identifies etiology

Surgical Wound Coding

- If surgery resolves the prior condition, code Z48.8–
  Encounter for surgical aftercare following surgery on the specific body system
  - Are you treating the condition or are you providing routine aftercare following surgery?
  - May be sequenced as primary or secondary diagnosis on Plan of Care
- Surgical wound complications T81.- through T87.-
  - Never code aftercare with a complication
Coding Skin Tears

- Most skin tears or partial thickness wounds are coded as superficial injuries
  - Require only simple wound care
  - Not considered skilled under Medicare

- Since most are caused by some type of injury (e.g., bumped on wheelchair), may be tempting to code as a trauma wound: *Be careful!!*

- May code as trauma wound ONLY if:
  - Skin tear is extensive – i.e., extends into dermis – or no longer has a flap
  - Wound is complicated – i.e., delayed healing, foreign body, primary infection
  - There is an underlying condition, such as diabetes or atherosclerosis, that could complicate healing

- Documentation must support the need for skilled care!
  - Payne Martin classification

Wound Assessment
Comprehensive Skin Assessment

• Time points and assessment time frames
  • First skin assessment
• Observe all body surfaces
  • Bony Prominences
  • Peri area
  • Under all dressings unless ordered not to remove
• Documentation format

Wound Identification

• Sources of information
  • Referral information, H&P, F2F
  • History from patient, family, caregiver
• Investigate and verify if necessary
  • Physician confirmation required!
• Provide accurate documentation
• Medical record must be consistent
Types of Wounds

- Pressure ulcers
- Venous stasis ulcers
- Arterial ulcers
- Diabetic ulcers
- Surgical wounds
- Other: trauma, burns, cellulitis

### Pressure Ulcers

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>presents as <strong>intact skin</strong> with non-blanchable redness of a localized area, usually over a bony prominence</td>
<td>partial thickness skin loss, <strong>shallow open ulcer</strong> with a red-pink wound bed <strong>without visible adipose tissue, slough, eschar or bruising</strong>. May present as an <strong>intact or open/ruptured serum-filled blister. No granulation tissue present</strong></td>
<td>full thickness skin loss, <strong>adipose tissue may be visible but bone, tendon, ligament, cartilage or muscle are not exposed</strong>. Slough or eschar may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Heals by <strong>granulation</strong></td>
<td>full thickness tissue loss with <strong>exposed fascia, muscle, tendon, or bone (Stage 4 structures)</strong>. Slough or eschar may be present. Often includes under-mining, epibole, tunneling. May destroy supporting tendons or joint structure</td>
</tr>
</tbody>
</table>
## Pressure Ulcers

<table>
<thead>
<tr>
<th>Stage?</th>
<th>Heal?</th>
<th>Coding/OASIS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I and II</td>
<td>Yes, they heal to near normal tissue</td>
<td>Once healed, not considered a current diagnosis, <strong>not counted on diagnosis list or on OASIS items</strong></td>
</tr>
<tr>
<td>Stage III and IV</td>
<td>No, they close, but do not <em>heal</em> – scar tissue is always weaker and prone to recurrent breakdown</td>
<td>Considered a current pressure forever, at worst stage it ever was. But, <strong>NOT counted on OASIS items; on diagnosis list?</strong> Up to you!</td>
</tr>
</tbody>
</table>

### Unstageable

- Covered by eschar or slough (no stage 4 structures visible)
- OR
- Covered with a dressing or device that cannot be removed (includes those sutured)
- OR
- Deep tissue injury (DTI) not due to trauma

### Unspecified

- No documentation of the stage of the pressure ulcer due to clinician did not observe or did not document the stage or describe the ulcer appearance

### Suspected DTI

- Characterized by purple or maroon localized area of discolored intact skin or a blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. May be preceded by tissue that is painful, firm, mushy, boggy, and warmer or cooler as compared to adjacent tissue
### Non-pressure Ulcers

<table>
<thead>
<tr>
<th>Arterial</th>
<th>Venous</th>
<th>Diabetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distal extremities</td>
<td>Distal lower extremities</td>
<td>Any location</td>
</tr>
<tr>
<td>Weak/absent pulses</td>
<td>Pulses may be palpable</td>
<td>Original etiology may vary</td>
</tr>
<tr>
<td>Usually no edema</td>
<td>Usually have edema</td>
<td>Patient must have DM dx</td>
</tr>
<tr>
<td>Round “punch-out” shape</td>
<td>Irregular shape</td>
<td>Requires physician or medical confirmation of</td>
</tr>
<tr>
<td>May be deep</td>
<td>Shallow</td>
<td>the diagnosis as a diabetic ulcer or ulcer</td>
</tr>
<tr>
<td>Minimal drainage,</td>
<td>Large amount of serous or</td>
<td>caused by diabetes</td>
</tr>
<tr>
<td>usually no bleeding</td>
<td>serosanguinous drainage</td>
<td>Clue to check blood sugars: document if</td>
</tr>
<tr>
<td>Minimal slough</td>
<td>Often have slough</td>
<td>hypoglycemia present</td>
</tr>
<tr>
<td>Usually not very painful</td>
<td>Usually very painful</td>
<td></td>
</tr>
</tbody>
</table>

### Injuries

<table>
<thead>
<tr>
<th>Minor</th>
<th>Serious</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasions</td>
<td>Lacerations</td>
<td>Thermal burns</td>
</tr>
<tr>
<td>Splinters</td>
<td>Open bites</td>
<td>Chemical corrosive burns</td>
</tr>
<tr>
<td>Non-thermal blisters</td>
<td>Puncture wounds</td>
<td>Frostbite</td>
</tr>
<tr>
<td>Bruising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-venomous Insect bites</td>
<td></td>
<td>Amputations</td>
</tr>
<tr>
<td>Skin tears per Payne Martin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or STAR classification</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Wound Identification Resource

WOCN *Clinical Fact Sheet for Quick Assessment of Leg Ulcers*

- Venous Insufficiency
- Arterial Insufficiency
- Peripheral Neuropathy

Available at [www.wocn.org](http://www.wocn.org)

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Components of Wound Assessment

- Location, identify laterality
- Size, shape, measurements
- Wound bed appearance
- Drainage
- Odor
- Surrounding tissue appearance
- Pain
Primary vs Secondary Intention

- The clinician must first assess if the wound is healing entirely by:
  - **primary intention** (well-approximated with no dehiscence), or
  - if there is a portion healing by **secondary intention**, (due to dehiscence, interruption of the incision, or intentional secondary healing).
- Surgical wounds healing by **primary intention** (approximated incisions) do not granulate, therefore the only appropriate responses would be Response 0 - Newly epithelialized or Response 3 - Not healing.
Primary Intention

• Re-epithelialized? Epithelialization is regeneration of the epidermis across a wound surface. (If there is no interruption in the healing process, this generally takes within a matter of hours to three days post-operatively.)

• If there is not full epithelial resurfacing such as in the case of a scab adhering to underlying tissue, the correct response would be "Not healing" for the wound healing exclusively by primary intention.

Healing by Primary Intention

- Does not include the appearance of the sutures
- Epithelial Resurfacing
- Scab adhering
Healing by Secondary Intention

Secondary Intention

Healing by primary intention

Healing by secondary intention
Healing Status

**Fully Granulating:**
- wound bed filled with granulation tissue to the level of the surrounding skin or new epithelium;
- no dead space, no avascular tissue (eschar and/or slough);
- no signs or symptoms of infection;
- wound edges are open.

**Early/Partial Granulation:**
- wound with ≥25% of the wound bed covered with granulation tissue;
- <25% of the wound bed covered with avascular tissue (eschar and/or slough);
- may have dead space;
- no signs or symptoms of infection;
- wound edges open.

**Not Healing:**
- wound with ≥25% avascular tissue (eschar and/or slough) OR signs/symptoms of infection OR clean but non-granulating wound bed OR closed/hyperkeratotic wound edges OR persistent failure to improve despite appropriate comprehensive wound management.

**Newly epithelialized**
- = surgical wound for 30 days

Wound Scenarios
M1306

• Mr. Ross has been on service before and it took several months to heal up his stage 4 ulcer. Mr. Ross is being admitted back to your agency. The assessing clinician notes the shiny pink divot on the right hip.

• Only ulcer is a closed stage 4—then answer to M1306 is NO. (Note skip pattern.)
  • OASIS response—no pressure ulcer
  • Clinical documentation—”epithelialized (closed) stage 4 pressure ulcer located at right hip”
  • Code according to stage? Up to you...L89.214

Mr. M

• Mr M was assessed to have a Stage 3 ulcer at SOC. He is being discharged today as he is being placed in a facility that specializes in pressure ulcers. The assessing clinician documents a ‘Stage 3, now unstageable due to eschar and slough.’

• How should M1311 be answered at DC?
  a. B1 = 1; B2 = 2; All others 0 or skipped
  b. E1 = 1; E2 = 0; All others 0 or skipped
  c. E1 = 1; E2 = 1; All others 0 or skipped
  d. E1 = 1; B1 = 0; B2 = 0; All others 0 or skipped
Stage 3 and 4

• If any bone, tendon or muscle or joint capsule (Stage 4 structures) is visible, the pressure ulcer should be reported as a Stage 4 pressure ulcer, regardless of the presence or absence of slough and/or eschar in the wound bed.

• A previously closed Stage 3 pressure ulcer that is currently open again should be reported as a Stage 3 pressure ulcer. A previously closed Stage 4 pressure ulcer that is currently open again should be reported as a Stage 4 pressure ulcer. Do NOT reverse stage.

• If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it challenging to know the highest numerical stage of the wound. The clinician should make every effort to contact previous providers (including patient’s physician) to determine the highest numerical stage of the pressure ulcer.

Discharge

| (M314) Current Number of Unhealed Pressure Ulcers/Irritations at Each Stage | Enter Number |
| --- |
| A1. Stage 2 Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as a intact or open purpuric blister. Number of Stage 2 pressure ulcers | ☐ |
| If 0 – Go to M311B1, Stage 3 |
| A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | ☐ |
| B1. Stage 3 Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May have undermining and tunneling. Number of Stage 3 pressure ulcers | ☐ |
| If 0 – Go to M311C1, Stage 4 |
| B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | ☐ |
| C1. Stage 4 Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers | ☐ |
| If 0 – Go to M311D1, Unstageable: Non-removable dressing/device | ☐ |
| C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | ☐ |
| D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device. Number of unstageable pressure ulcers/injuries due to non-removable dressing/device | ☐ |
| If 0 – Go to M311F1, Unstageable: Slough and/or eschar | ☐ |
| D2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | ☐ |
| E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar. Number of unstageable pressure ulcers/injuries due to coverage of wound bed by slough and/or eschar | ☐ |
| If 0 – Go to M311F1, Unstageable: Deep tissue injury | ☐ |
| E2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | ☐ |
| F1. Unstageable: Deep tissue injury | ☐ |
| Number of unstageable pressure injuries presenting as deep tissue injury | ☐ |
| If 0 – Go to M324 | ☐ |
| F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC | ☐ |

The pressure ulcer at ROC was covered by a non-removable dressing. The first documentation noted of stage during the episode is stage 2. At discharge the pressure ulcer is stage 3.
**SOC**

<table>
<thead>
<tr>
<th>(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage</th>
<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1.</strong> Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>B1.</strong> Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers</td>
<td>[ ]</td>
</tr>
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<td><strong>C1.</strong> Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>D1.</strong> Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>E1.</strong> Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</td>
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<td><strong>F1.</strong> Unstageable: Deep tissue injury Number of unstageable pressure injuries presenting as deep tissue injury</td>
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</table>

65

**Discharge**

<table>
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<tr>
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<th>Enter Number</th>
</tr>
</thead>
<tbody>
<tr>
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<td>[ ]</td>
</tr>
<tr>
<td><strong>B1.</strong> Number of those Stage 2 pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>B2.</strong> Number of those Stage 2 pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>C1.</strong> Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>C2.</strong> Number of those Stage 4 pressure ulcers that were present at most recent SOC/ROC</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>D1.</strong> Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers/injuries due to non-removable dressing/device</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>E1.</strong> Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</td>
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<td><strong>E2.</strong> Number of those unstageable pressure ulcers that were present at most recent SOC/ROC</td>
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<td><strong>F1.</strong> Unstageable: Deep tissue injury Number of unstageable pressure injuries presenting as deep tissue injury</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>F2.</strong> Number of those unstageable pressure injuries that were present at most recent SOC/ROC</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

At SOC, patient has three small stage 2 pressure ulcers on sacrum.

At DC, sacral area is assessed: two of the stage 2 pressure ulcers have merged, and the third ulcer has increased to a stage 3.
Ms. P

At the SOC, Ms. P was admitted with a diagnosis of CVA with right hemiparesis and assessed to have a 1 cm x 1 cm x < 0.1 cm Stage 2 pressure ulcer on her coccyx.

Ms. P continued

Ms. P continued to decline at home, with decreased appetite, frequent transient ischemic attacks, and a wish not to be hospitalized again. After a palliative care consult, the patient and family agreed to hospice care.

Upon discharge from home care, Ms. P was noted to have a pressure ulcer completely covered with eschar on her left heel and a Stage 3 pressure ulcer 3 cm x 2 cm x 0.4 cm on her coccyx.
Healing Status

- Mrs. J’s medi-port was accessed with a Huber needle, using good technique, to perform a weekly flush. After de-accessing the port, there was no perceptible wound. No other surgical wounds.

- Response 0 – Newly epithelialized for implanted venous access devices and infusion devices when the insertion site is healed and without signs and symptoms of infection.

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Healing Status

- Mr. K is undergoing chemotherapy treatments at an out-patient oncology clinic. Home care is providing assessment of response to treatment, teaching on management of side effects, therapy for fall prevention.

- Response 3 - Some sites, because they are being held open by a line or needle, cannot fully granulate and may remain "non-healing" while the line or needle is in place. 4bQ112.6.1.
What about this??

A patient with a diabetic ulcer on the bottom of his left foot has it debrided, on admission to home care can see adipose tissue - considered a diabetic ulcer on OASIS (not counted in any item) and ICD-10 coding as a diabetic ulcer with depth of tissue damage with adipose tissue visible: E11.621 + L97.422

The ulcer isn't healing, so patient has an autologous skin graft - now a surgical wound on OASIS, code aftercare following surgery on skin, still coded as a diabetic ulcer on the diagnosis list with the L97 code for WHAT DEPTH of tissue involvement? Still code the adipose tissue depth since that is what it was before the graft?

Rationale

The OASIS guidance says to mark it as a surgical wound (per the Jan. 2019 OASIS Q&A#5), but watch the wording: "For OASIS coding purposes, when any type of ulcer is treated surgically with any kind of graft or flap, it is considered a surgical wound for M1340 until approx. 30 days after complete re-epithelialization." It is marked as a surgical wound (Yes on M1340), but that only applies to answering the OASIS items.

ICD-10 coding guidance is different: the skin graft doesn't change the original etiology of the wound, so this wound would still be coded as a diabetic ulcer (E11.621 + L97.-). The big question: what to consider the depth of tissue damage on the L97 code after the graft is done? Code it as it was documented before the graft? (Query sent to Coding Clinic)
Quality Measures

Pressure Ulcer Quality Measure

Numerator = number of quality episodes in which assessment at DC indicates one or more new or worsened Stage 2-4 or unstageable pressure ulcer/injuries compared to SOC/ROC assessment

Denominator = All quality episodes except:
End in Death at Home or Transfer to Inpatient Facility
Or
No assessment completed at BOTH SOC/ROC and DC
Or
DC assessment does not have usable response for M1311a-f
Current Score

• How often patients developed new or worsened pressure ulcers (old quality measure)

<table>
<thead>
<tr>
<th>Your agency</th>
<th>CO State Average</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.3%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

Surgical Wound Quality Measure

• Percentage of home health quality episodes during which the patient demonstrates an improvement in the condition of surgical wounds.

• End-result outcome measure using:
  • (M1340) Does this patient have a Surgical Wound?
  • (M1342) Status of Most Problematic (Observable) Surgical Wound
Surgical Wound Quality Measure

**Numerator** = Number of home health quality episodes where the patient has a better status of surgical wounds at discharge compared to start (or resumption) of care

**Denominator** = Number of home health quality episodes ending with a discharge during the reporting period, except:

- HH quality episodes for which the patient, at SOC/ROC, did not have any surgical wounds or had only a surgical wound that was unobservable or fully epithelialized, or
- HH episodes that end with inpatient facility transfer or death at home

Current Scores

- How often patients’ wounds improved or healed after an operation.

<table>
<thead>
<tr>
<th>Your agency</th>
<th>CO State Average</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>92.9%</td>
<td>91.2%</td>
</tr>
</tbody>
</table>
Potentially Avoidable Event

Increase in Number of Pressure Ulcers/Injuries:

• Percentage of home health quality episodes during which the patient had a larger number of pressure ulcers/injuries at discharge than at start of care.

• OASIS items used:
  • (M1306) Unhealed Pressure Ulcer/Injury at Stage 2 or Higher
  • (M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

• Not on HHCompare – check your CASPER reports

Potentially Avoidable Event

**Numerator** = Number of home health quality episodes where the discharge assessment indicates more pressure ulcers/injuries (stage 2 or higher, or unstageable) at discharge than at SOC / ROC

**Denominator** = Number of home health quality episodes ending with a discharge during the reporting period, **except**:

Home health quality episodes that end with inpatient facility transfer or death at home
Climb Out of Wound Downsides!

• Confirm etiology/type of wound with physician
• Perform complete wound assessment
• Describe all components of wound
• Complete OASIS items per guidance
• Assign diagnosis codes to Plan of Care
• Carry out wound care orders, instruct procedure
• Manage co-morbidities, follow best practices
• Coordinate care and communicate with disciplines, patient, family/caregivers, physicians
• Document consistently
• For poor quality scores, consider a QAPI project

What questions do you have?

Lisa@selmanholman.com	Teresa@selmanholman.com

Selman-Holman & Associates, A Briggs Healthcare Company

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